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AUTHORIZATION TO RELEASE INFORMATION FOR PATIENT

I voluntarily authorize SARKIS FAMILY PSYCHIATRY to:

______ Release to:
______ Obtain from: ____

Name of person/facility

____

Mailing Address: City, State, Zip

Written and/or verbal information from the record of:

____

Patient

____

Date of Birth

This information is to be used for the purpose of:
______ My follow up care
______ Other (Specify) _____________________________________

Specific Information to be released:
______ All records
______ History/ Physical and/or Admission/ Discharge Summary
______ Lab Reports, EKG, Operative Reports
______ Psychiatric/Psychological Consults
______ Other (Specify) _____________________________________

1. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. ______**Initial**
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorize the disclosure health information as stated.

(over the age of 14)
Signature of patient:____ Date: ______________

Signature of Parent/Guardian: _________________________Relationship: ______________

Witness: ____ Date: ______________